Choices for Care – VT Long-Term Care Medicaid

Nursing Facility/Hospital Swing Bed Change Report Form

Complete all sections that apply for active Choices for Care participants.

Individual Name: _____

SSN: _____ Date of Birth:_____

Facility Name: _____ Phone:_____

A. Hospital Admission/Discharges

☐Admission to Hospital date: _____ Estimated return date (if known): _____
Hospital: _____ Bed hold? ☐Yes ☐No

☐Re-admission from Hospital date: _____/ Total # of days in hospital _____
Payment source upon re-admission: _____
If payment source upon re-admission is other than Medicaid, complete section B.

B. Change in Payment Source

☐Change from VT Medicaid coverage to the following payment source:
- ☐MEDICARE effective date _____
- ☐Other insurance effective date _____ / Insurance:_____
- ☐Private pay effective date _____

☐Return to VT Medicaid coverage (Choices for Care) date: _____
Total # of days at previous payment source _____

☐MEDICARE Co-insurance start date: _____ through end date: _____

Comments (if needed):

Person Completing Form (print): _____

Signature: _____ Date: _____

Copy to:
➢**Local Department for Children and Families Office**
and
➢ **Office of Vermont Health Access**
312 Hurricane Lane, Suite 201, Williston, VT 05495
PHONE: (802) 879-5900 FAX: (802) 879-5919